TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-16-0224-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 25, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider has outlined key components regarding patient's visit with him."

Amount in Dispute: $258.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 23, 2015	99204	$258.08	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payer deems the information submitted does not support this level of service
   - W3 – Request for reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 150 – "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203 (b) states, requires that

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;

   Review of the submitted information finds that the submitted code is 99204 – "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 components:

   The *CMS Evaluation and Management Guide* found at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf* Details the documentation requirements associated with evaluation and management code selection guide can be found at the "Documentation Worksheet" found at http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00004968&_adf.ctrl-state=1bmfh4g1hv_50&_afrLoop=7939673053147000#!

   A comprehensive history; Requires documentation to include;

   An **extended HPI** – Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions. The documentation included in this dispute show (1) condition. The requirements of the code are not met.

   A **complete ROS** inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented. The documentation included in this dispute show (1) elements of present illness. The requirements of the code are not met.

   A **complete PFSH** is a review of two or all three of the areas, depending on the category of E/M service. A complete PFSH requires a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient. A review of two history areas is sufficient for other services. The documentation included in this dispute show (1) past medical family social history. The requirements of the code are not met.

   A comprehensive examination; Includes eight or more organ systems. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by bullet is expected. The documentation included in this dispute shows (1) Body area and (1) Organ System. The requirements of the code are not met.

   Medical decision making of moderate complexity; The documentation included in this dispute show the complexity to be "Low". The requirements of the code are not met.

   The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. Per Rule 134.203(b) the submitted documentation requirements of the evaluation and management code in dispute was not met. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 21, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.